NOTICE OF INDEPENDENT REVIEW DECISION

September 6, 2002

RE: MDR Tracking #: M2-02-0965-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 49 year old female sustained a work related injury on ___ when she cut her wrist on a knife while cleaning a counter. The patient required sutures and antibiotics on her emergency room visit. The patient has been treated with chiropractic care, physical therapy, medications, and injections to the affected area. A psychologist evaluated the patient and due to her complaints of increased pain, her treating physician has recommended that the patient undergo a 20-day, multi-disciplinary pain management program.

Requested Service(s)

20 day, multi-disciplinary pain management program

Decision

It is determined that the 20 day, multi-disciplinary pain management program is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had pain since her injury in ___. She has developed psychological traits of chronic pain syndrome. She has undergone extensive treatment including: medications (non-steroidal anti-inflammatory drugs, Zonegran, Effexor, Vicodin, Topamax, Ultram, Lorcet, and Sonata), occupational therapy,

stellate blocks x 4, median nerve blocks x 4, and spinal cord stimulation trial, all with only partial success. Psychological evaluation reveals traits such as poor coping, sleep disturbance, anxiety, depression, decreased activity, and a high sense of disability due to the pain. Patients with this type of chronic pain respond best to a 20-day multidisciplinary pain program. (Ref: J. Back; "Clinical practice guidelines for chronic non-malignant pain syndrome patients II: An evidence-based approach", Musculoskeletal Rehabil Jan 1; 13:47-58.) Therefore, the 20 day, multi-disciplinary pain management program is medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,